

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? (x) Yes () No
Requestor's Name and Address Wol-Med 2436 I-35 East South, Suite, 336 Denton, Texas 76205	MDR Tracking No.: M4-04-4228-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Amerisure Mutual Insurance Company Box 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.: 0000852923 001

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/21/03	01/23/03	99213	\$48.00	\$0.00
04/08/03	04/08/03	99213	\$48.00	\$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor's position statement states, "The carrier denied payment for dates of service 01/21/-03 and 04/08/03 using PEC-L. This is an incorrect PEC. We were the treating doctor on this date of service. The carrier paid dates of service before this date and after this date."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier states in their position statement, "The physician Dr. W, MD is neither the treating physician nor a referral from the treating physician. Dr. P is the treating physician of record and nor did the treating physician refer the claimant to Dr. W, he simply just went to a new doctor without the following guidelines, for which I have repeatedly discussed with all parties."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Per rule 126.9 "...the employee shall submit to the filed office handling the claim, reasons why the current treating doctor is unacceptable." The Commission does not have any record that the employee requested a change of treating doctor in the form of a TWCC-53 form. Therefore, based on this information reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled reimbursement.

Ordered by:

Authorized Signature

Michael Bucklin

Typed Name

01/03/05

Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____